# Sierra Family Care Adult History Form

Name:_____ Age:_____ DOB:_____ Today's Date:_____

**Hospitalizations/Surgeries/Illnesses/Procedures:**

| Year | Type | Year | Type |
|---|---|---|---|
| ____ | _____ | ____ | _____ |
| ____ | _____ | ____ | _____ |
| ____ | _____ | ____ | _____ |
| ____ | _____ | ____ | _____ |
| ____ | _____ | ____ | _____ |
| ____ | _____ | ____ | _____ |

**Medication/Food/Environment Allergies/Intolerances:** _____

**Medications you take:** (Attach your own list if not enough room)

| Name | Dose | Times per day | Name | Dose | Times per day |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

**Other doctors you see and their specialties:** _____

_____

**When was your last:** (Please list the year) **Colonoscopy:**_____ **Mammogram:**_____ **Pap:**_____
**Menstrual Period:**_____ **Tetanus Vaccine:**_____ **Pneumonia Vaccine:**_____ **Flu Vaccine:**_____
**Tb/PPD (Tuberculosis) Test:**_____ **HIV Test:**_____ **Hepatitis C Test:**_____

**Do you have or have you had any of the following illnesses or conditions:** (Circle)
Diabetes / Thyroid Disease / Anemia / Blood Clots / Blood Transfusions / Bleeding Disorder / Hi Blood Press / Heart Attack / Heart Disease / Stroke / Seizure / Brain Injury / Asthma / COPD / Emphysema / Pneumonia / Lung Disease / Allergies / Acid Reflux / Ulcer / Colitis / Irritable Bowel / Colon Polyps / Liver Disease / Gall Bladder Disease / Gall Stones / Kidney Disease / Kidney Stones / Problem with Genitals or Bladder or Bowel / Tuberculosis / HIV / Hep C / Hep B / Any Hep / Sexually Transmitted Illness / Anxiety / Depression / Nervous Disorder / PTSD / Chronic Pain / Fibromyalgia / Chronic Fatigue / Lupus / Autoimmune Disease

Are you disabled? (Circle) No / Yes What is your disability? _____
Spinal disk or joint problems? (Circle) Cervical / Thoracic / Lumbar / Other:_____
History of Cancer:_____
Other or additional information:_____

**Family History: (Please only list blood-related mother, father, sisters, and brothers)**
Have any of your **blood relatives** had any of the following? Please list their relation to you below.

| | | | |
|---|---|---|---|
| Birth Defects_____ | Hi or Low Thyroid_____ | Tuberculosis_____ | Stroke_____ |
| Blood Clots_____ | Heart Trouble_____ | Colon Polyps_____ | Lupus_____ |
| Allergies_____ | Lung Disease_____ | Diabetes_____ | Asthma_____ |
| Seizure_____ | Kidney Disease_____ | Depression_____ | Anemia_____ |
| Cancer (**type**)_____ | Mental Health Issues_____ | Other:_____ | |

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**Social History:** (Circle all that apply and/or fill in the blanks)
Are you: Married / Widowed / Divorced / Single / Separated / Living Together
Do you have **Children:** No / Yes How many? _____
Do you have **Pets:** No / Yes How many and what kinds? _____
What is your **Occupation:**_____

**Tobacco/Alcohol Use:**
Do you use **Tobacco:** No / Ex-Smoker / Yes / Daily / Occasional / Rare
**If you use Tobacco**, then what kind and how often:_____
**If you are an ex-smoker**, then when did you quit smoking:_____
Do you consume **Alcohol:** No / Yes What kind: Beer / Wine / Liquor
**If yes**, then how often do you consume alcohol: 4+ times a week / 2-3 times a week / 2-4 times a month / Occasional
How many alcoholic beverages do you consume when you drink: 1-2 / 3-4 / 5-6 / 7-9 / 10+
How often do you consume 6+ alcoholic beverages: Never / Less than monthly / Monthly / Weekly / Daily

**Exercise:**
Highest education level completed? _____
How many days per week do you exercise? _____ Minutes per day? _____

**Financial Status/Stress:**
Describe your difficulty paying for the very basics like food, housing, medical care, and heating: (Circle)
Very hard / Hard / Somewhat hard / Not very hard / Decline to specify
What is your stress level most of the time? None / Low / Some / Moderate / High / Extreme

**Socialization:**
In a typical **week**, how many times do you talk on the phone with family/friends/neighbors? _____
In a typical **week**, how often do you get together with friends or relatives? _____
In a typical **year**, how many times do you attend church or religious services? _____
Do you belong to any clubs or organizations? Yes / No

**Violence:**
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? (Circle) Yes / No
Within the last year, have you been afraid of your partner or ex-partner? (Circle) Yes / No
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? (Circle) Yes / No
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? (Circle) Yes / No

**Gender/Sexual Orientation:**
What is your gender identity? (Circle) Male / Female / Transgender Male/Man/Female-to-Male / Transgender Female/Woman/Male-to-Female / Genderqueer / Decline to specify / Other (please specify)_____
What is your sexual orientation? (Circle) Straight / Gay / Bisexual / Decline to specify / Undecided / Something else (please describe)_____

**Implantable Devices:**
Do you have an implantable device? (Circle) Yes / No
If you have an implantable device, then what is the device's **Unique Device Identifier**? _____
And when was the device implanted? _____

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## Sierra Family Care Patient Information Sheet

**Mr./Mrs./Ms./Miss (Circle One)** **Male or Female (Circle one)**

**Patient's Name:**_____ **Suffix:**_____

**Age:**_____ **Date of Birth:**_____ **Social Security Number:**_____

**Cell#:**_____ **Home#:**_____ **Work#:**_____

**Email:**_____

**Address/City/State/Zip:**_____

**Mailing Address:**_____

**Preferred Pharmacy/Zip Code:**_____

**Preferred Language:**_____ **Ethnicity:**_____

**Emergency Contact: Name:**_____ **Relation:**_____

**Phone#:**_____ **Phone Type: Cell/Home/Work (Circle One)**

**Address:**_____

**If patient is a minor, list other parent/guardian name/phone#:**_____

**Financial Responsibility: Relation to patient:**_____

**Name:**_____

**Employer:**_____ **Occupation:**_____

**Address:**_____

**Date of Birth:**_____ **Gender:**_____ **Social Security Number:**_____

**Primary Phone:**_____ **Secondary Phone:**_____

**I consent to treatment necessary for the care of the patient named above.**
**I allow fax and electronic transmittal of my records, if necessary.**
**I understand that I will receive up to 3 statements for any unpaid services and, if still unpaid, then my account will be sent to collections.**
**I understand that payment is due at the time of service.**
**I agree to pay all reasonable attorney fees and collection costs in the event of default of payment.**
**I further authorize and request that my insurance payments be directly made to Sierra Family Care.**
**I understand that this office uses an electronic medical record.**
**I have read and fully understand the above consent for treatment, financial responsibility, and release of medical information and insurance authorization.**

**Date:**_____ **Signature:**_____

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# Sierra Family Care Payment Policy

Thank you for choosing us as your primary care provider. We are committed to the provision of superior and personalized care.

This payment policy outlines our expectation of payment for services we render. **It is required that you read and sign this agreement in order to be a patient of Sierra Family Care.**

1. **No Insurance:** Refer to the "Uninsured/Cash Patient Affidavit."
2. **Insurance (Participating Provider):** We participate with numerous insurance plans. That means we will bill those companies and accept the contracted rate for care. It is your responsibility to know the limits and coverage of your insurance. Please contact your insurance with any questions you may have in regard to contracted providers.
3. **Insurance (Non-Participating Provider):** If you have an insurance with an out-of-network benefit, then Sierra Family Care may still be able to provide services to you. Be aware that in this situation, your co-payment and deductible will likely be higher. If you have further questions, then please contact your insurance company.
4. **Co-Payment and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with the insurance company. These fees cannot be waived.
5. **Non-Covered Services:** Please be aware that some, and perhaps all, of the services you receive may be considered by your insurance company or Medicare to be "non-covered" services or even considered to be "not-reasonable or medically necessary" as outlined by their own standards for coverage of services. Be assured that we only provide services in agreement with you and that we feel are indeed necessary for your physical or mental well-being. **As such, any services deemed not coverable by your insurance will be your responsibility to pay for.**

   ***Examples:***
   1. **Vaccines and Tests:** Some vaccines and screening tests at certain ages, although advised, may not be considered covered services by your insurance plan.
   2. **Timing:** Payers often deny certain services because they perceive the service as medically unnecessary if it is performed sooner than expected by the payer.
   3. **File/Form Fees:** Expenses incurred for the processing of patient, pharmacy, governmental, or insurance requests that require medical record review and documentation with or without a change in care plan are not billable to payers.

   **File/Form Fees range from $3 per event that requires medical record review and documentation between office visits (including prescription requests) to $25 or more for the completion of a wide variety of special forms** related to one's state of health, disability, retirement, school, travel, and specialized examination and documentation beyond or in addition to that which is usually covered at an office visit for your healthcare.

6. **How to Avoid Fees:** You do not like paying them and we do not like charging them. The vast majority of file fees are for prescription refill requests made between office visits. Your participation in your care will result in avoiding these fees if you would simply **bring all of your medications to every visit** and make sure you have enough refills to get you through to your next scheduled office visit.
7. **Claims Submission: Synapse** is our contracted billing service. We will submit your claim via Synapse and assist you in getting your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company. We will also abide by any agreement that we may have in place with your insurance company.
8. **Coverage Changes:** If your insurance changes, then please notify us before your next visit so we can make appropriate changes to help you maintain your benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
9. **Non-Payment:** If your account is over 90 days past due, then you will receive a letter stating that you have 20 days to pay your account in full. Please immediately contact our office manager if you need to arrange partial payments. **Please be aware that if a balance remains unpaid, then we will refer your account to a collection agency** and you, and/or your immediate family members for whom you are the guarantor, may be discharged from the practice. If this does occur, you will be notified by mail that you have 30 days to find alternative medical care after which time we will no longer provide any services to you and/or your covered family members.

The policies outlined above are designed to allow us to work together more efficiently for the benefit of our patients. Thank you for your understanding in this matter.

I have read and understand the payment policy and agree to abide by this payment policy.

Name: (print) _____

Signature: _____

Date: _____

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The federal government has published regulations designed to protect the privacy of my health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other healthcare providers, and health plans.

I, _____, have reviewed a copy of the Notice of Privacy Practices from Sierra Family Care.

_____
Signature

_____
Date Signed